Child's Name _____
Date of Birth_____

Child Care Resource & Referral, Inc., Head Start
ATTENTION: Head Start Health Services Coordinator
126 Woodlake DR SE
Rochester, MN 55904
1-507-287-2009
Fax number: 507-287-2411

A yearly dental examination is a federally mandated Head Start program requirement

Services			**Date Services Completed**	**Fee**
Examination/Basic Screening Survey (BSS)				
X-Ray (if necessary)				
Preventative Services (if necessary) Prophylaxis (if necessary)				
Fluoride Treatment (if necessary)				
Sealants (if necessary)				
Restorative Services (if necessary)				
	Est. Fee	Approval		
		TOTAL		

*IF HEAD START will be billed for treatment, as estimate **MUST** be approved in advance!*

Please Check:
- ☐ has completed all necessary dental treatment and should return in ____months for a routine visit.
- ☐ treatment discontinued.
- ☐ fluoride prescribed and dosage level _____.
- ☐ this child needs nutrition counseling from a dental standpoint.
- ☐ my office will provide this.
- ☐ you should arrange for this.

Please List Future Routine or Treatment Scheduled Appointment Date(s): _____

Comments:_____

I hereby certify that the services listed above have been performed:

Signature of Dentist/Hygienist Print Name

Address Phone